

		FOR OHF USE					

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**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0027367</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>FAIR ACRES NURSING HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>514 EAST JACKSON STREET</u> <u>DUQUOIN</u> <u>62832</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>PERRY</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>ROGER W. BAGLEY</u> (Title) <u>CONTROLLER</u>	
<b>Telephone Number:</b> <u>(618)542-4731</u> <b>Fax #</b> <u>(618)542-4732</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )	
<b>IDPA ID Number:</b> <u>371119686001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>10/10/82</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>ROGER W. BAGLEY</u> Telephone Number: <u>(618)549-8331</u> <u>JAMESTOWN MGMT</u>			

Facility Name & ID Number FAIR ACRES NURSING HOME# 0027367 Report Period Beginning: 01/01/01 Ending: 12/31/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>29</u>	Skilled (SNF)	<u>29</u>	<u>10,585</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>45</u>	Intermediate (ICF)	<u>45</u>	<u>16,425</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		<u>3,364</u>	<u>884</u>	<u>4,248</u>	8
9	SNF/PED					9
10	ICF	<u>15,388</u>	<u>5,279</u>		<u>20,667</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,388</u>	<u>8,643</u>	<u>884</u>	<u>24,915</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 92.24%

D. How many bed-hold days during this year were paid by Public Aid?

83 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)OUTPATIENT THERAPYF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1966

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 29 and days of care provided 884Medicare Intermediary ADMINISTAR FEDERAL

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: \_\_\_\_\_

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

FAIR ACRES NURSING HOME

# 0027367

Report Period Beginning:

01/01/01

Ending:

12/31/01

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	106,402	6,303	6,131	118,836		118,836		118,836		1
2	Food Purchase		77,978		77,978	2,851	80,829	(272)	80,557		2
3	Housekeeping	58,354	5,522		63,876	1,121	64,997		64,997		3
4	Laundry	41,292	5,347		46,639		46,639		46,639		4
5	Heat and Other Utilities			57,451	57,451	341	57,792		57,792		5
6	Maintenance	24,559	13,811	20,440	58,810		58,810		58,810		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	230,607	108,961	84,022	423,590	4,313	427,903	(272)	427,631		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			900	900		900		900		9
10	Nursing and Medical Records	651,597	23,493	107,375	782,465	(4,672)	777,793		777,793		10
10a	Therapy	14,383		9,809	24,192		24,192		24,192		10a
11	Activities	28,500	1,733	2,160	32,393		32,393		32,393		11
12	Social Services	21,936		2,160	24,096		24,096		24,096		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	716,416	25,226	122,404	864,046	(4,672)	859,374		859,374		16
	<b>C. General Administration</b>										
17	Administrative	46,737			46,737	46,458	93,195		93,195		17
18	Directors Fees										18
19	Professional Services			155,090	155,090	(85,408)	69,682	(62,204)	7,478		19
20	Dues, Fees, Subscriptions & Promotions			8,488	8,488	146	8,634	(3,067)	5,567		20
21	Clerical & General Office Expenses	22,650	6,847	4,873	34,370	20,566	54,936	(405)	54,531		21
22	Employee Benefits & Payroll Taxes			148,677	148,677	10,657	159,334		159,334		22
23	Inservice Training & Education			211	211		211		211		23
24	Travel and Seminar			4,993	4,993	122	5,115		5,115		24
25	Other Admin. Staff Transportation					1,238	1,238		1,238		25
26	Insurance-Prop.Liab.Malpractice			32,485	32,485	905	33,390		33,390		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	69,387	6,847	354,817	431,051	(5,316)	425,735	(65,676)	360,059		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,016,410	141,034	561,243	1,718,687	(5,675)	1,713,012	(65,948)	1,647,064		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number      FAIR ACRES NURSING HOME      #0027367      Report Period Beginning:      01/01/01      Ending:      12/31/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			23,085	23,085	1,288	24,373	10,975	35,348			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					717	717	14,331	15,048			33
34	Rent-Facility & Grounds			222,000	222,000	3,670	225,670	(222,000)	3,670			34
35	Rent-Equipment & Vehicles			114	114		114		114			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			245,199	245,199	5,675	250,874	(196,694)	54,180			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,856	60,756	92,612		92,612		92,612			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		31,856	101,271	133,127		133,127		133,127			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,016,410	172,890	907,713	2,097,013		2,097,013	(262,642)	1,834,371			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number FAIR ACRES NURSING HOME

# 0027367

Report Period Beginning: 01/01/01

Ending: 12/31/01

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	734	30		9
10	Interest and Other Investment Income	(1,674)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(272)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(405)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,404)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(463)	20		28
29	Other-Attach Schedule	(200)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (4,684)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(257,958)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (257,958)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (262,642)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

STATE OF ILLINOIS  
FAIR ACRES NURSING HOME

Page 5A

ID# 0027367  
Report Period Beginning: 01/01/01  
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DETAIL FOR LINE 29 SCHEDULE VI	\$	1
2	ELIMINATE 1 YR OF 2 YR IDPH LICENSE	(200)	20
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(200)	49

## Summary A

12/31/01

12/31/01

[illegible]

## Summary B

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]



Facility Name &amp; ID Number FAIR ACRES NURSING HOME

# 0027367

Report Period Beginning:

01/01/01

Ending:

12/31/01

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		SENIOR MANOR NURSING CENTER	SPARTA			
		CANTERBURY MANOR NURSING CENTER	WATERLOO	Twin Willows Land	DuQuoin	Real Estate Rental
		FAIRVIEW NURSING CENTER	DUQUOIN	Trust		
				Jamestown Mgmt	Carbondale	Management
				Corporation		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	RENT	\$ 222,000	TWIN WILLOWS LAND TRUST	100.00%	\$	(222,000)	1
2	V	32	INTEREST EXPENSE		TWIN WILLOWS LAND TRUST	100.00%	2,942	2,942	2
3	V	30	DEPRECIATION		TWIN WILLOWS LAND TRUST	100.00%	10,241	10,241	3
4	V	33	REAL ESTATE TAXES		TWIN WILLOWS LAND TRUST	100.00%	14,331	14,331	4
5	V	32	INTEREST INCOME		TWIN WILLOWS LAND TRUST	100.00%	(1,268)	(1,268)	5
6	V	19	JAMESTOWN MGMT FEE	147,862	JAMESTOWN MANAGEMENT CORP	0.00%	85,658	(62,204)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 369,862			\$ 111,904	\$ * (257,958)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

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Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/01 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO COST REPORT					Hours	Percent	Description	Amount		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/01 Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization JAMESTOWN MANAGEMENT CORP  
 Street Address 1001 E MAIN BLDG 4A  
 City / State / Zip Code CABONDALE, IL 62901  
 Phone Number (618)549-8331  
 Fax Number (618)549-0133

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	18,158	\$ 8,066	\$	2,524	\$ 1,121	1
2	5	UTILITIES	HOURS OF SERVICE	18,158	2,451		2,524	341	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	10,440	334,264	334,264	1,451	46,458	3
4	19	LEGAL AND ACCOUNTING	HOURS OF SERVICE	18,158	1,795		2,524	250	4
5	20	LICENSES AND DUES	HOURS OF SERVICE	18,158	1,053		2,524	146	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	7,718	128,698	128,698	1,073	17,892	6
7	21	OFFICE SUPPLIES	HOURS OF SERVICE	18,158	19,240		2,524	2,674	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	18,158	63,567		2,524	8,836	8
9	24	SEMINARS	HOURS OF SERVICE	10,440	877		1,451	122	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	10,440	8,910		1,451	1,238	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158	6,513		2,524	905	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158	9,267		2,524	1,288	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	18,158	5,160		2,524	717	13
14	34	RENT	HOURS OF SERVICE	18,158	26,400		2,524	3,670	14
15									15
16		*** EXCESS SALARY OF RELATED INDIVIDUAL HAS BEEN ELIMINATED							16
17		PRIOR TO THE COST REPORT							17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 616,261	\$ 462,962		\$ 85,658	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	FAIR ACRES NURSING HOM	X		pay off existing construction	\$2,760.00	05-05-99	\$ 91,089	\$ 18,057	07-12-02	0.0850	\$ 2,942	1	
2				loan								2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$2,760.00		\$ 91,089	\$ 18,057			\$ 2,942	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 91,089	\$ 18,057			\$ 2,942	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **FAIR ACRES NURSING HOME**# **0027367** Report Period Beginning: **01/01/01** Ending: **12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2000 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>14,331</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>14,331</b>	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>14,331</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	<b>12,120</b>	8	
	1997	<b>12,284</b>	9	
	1998	<b>13,989</b>	10	
	1999	<b>14,204</b>	11	
	2000	<b>14,331</b>	12	
<b>LINE 7 DOES NOT AGREE WITH THE AMOUNT OF SCH V LINE 33 BECAUSE</b>				
<b>LINE 7 DOES NOT INCLUDE THE JAMESTOWN ALLOCATION OF \$717 FROM</b>				
<b>SCH VIII PAGE 8. TO RECONCILE R E TAX ON PG 4 LINE 33 ADD LINE 7'S 14331+</b>				
<b>JAMESTOWN ALLOCATION OF 717 = TOTAL RE TAX OF 15048</b>				
		<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2000	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    FAIR ACRES NURSING HOME    COUNTY    PERRY

FACILITY IDPH LICENSE NUMBER    0027367

CONTACT PERSON REGARDING THIS REPORT    ROGER W. BAGLEY

TELEPHONE    (618)549-8331    FAX #:    (618)549-0133

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	1-61-0270-010	sec 17 twp 06 rng 01 s sw sw ne	\$ 14,331.30	\$ 14,331.30
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		<b>TOTALS</b>	\$ 14,331.30	\$ 14,331.30

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    YES    X    NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 17,703

B. General Construction Type:
 Exterior
 MASONRY
 Frame
 MASONRY & STEEL
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NOT APPLICABLE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 \_\_\_\_\_

2. Number of Years Over Which it is Being Amortized:
 \_\_\_\_\_

3. Current Period Amortization:
 \_\_\_\_\_

4. Dates Incurred:
 \_\_\_\_\_

Nature of Costs:
 \_\_\_\_\_
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	BUILDING	125,722		\$ 18,792	1
2					2
3	TOTALS	125,722		\$ 18,792	3

**XL OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	74	1966	1966	\$ 179,381	\$	40	\$ 4,485	\$ 4,485	\$ 159,217
5		1966	1966	175,379		20			175,379
6		1987	1987	263,386		40	6,585	6,585	95,482
7									
8									
<b>Improvement Type**</b>									
9	FULLY DEPRECIATED	1974		15,221					15,221
10	FULLY DEPRECIATED	1980		5,082					5,082
11	BUILDING IMPROVEMENT	1971		2,768					2,768
12	BUILDING IMPROVEMENT	1972		1,823					1,823
13	BUILDING IMPROVEMENT	1973		9,170					9,170
14	BUILDING IMPROVEMENT	1981		1,158		10 TO 15			1,158
15	ROOF	1982		3,890		15			3,890
16	LAND IMPROVEMENT	1982		10,400		15			10,400
17	FIRE ALARM & SEAL PARKING LOT	1983		4,351		10 TO 15			4,351
18	A/C ROOF TOP, WATERLINE, STORAGE BUILDING	1984		13,711		20	386	386	12,745
19	SEWER REPAIR	1987		1,330	89	15	89		1,290
20	PARKING LOT & PLUMBING	1988		14,182	77	15 TO 25	720	643	9,720
21	A/C COMPRESSOR & ROOF	1989		23,834	61	15 TO 30	825	764	9,549
22	ROOF REPAIR	1990		18,354		30	612	612	7,038
23	WATER HEATER & A/C UNITS	1990		4,675	38	15	312	274	3,587
24	CABINETS & NURSES STATION	1992		6,893	460	15	460		4,370
25	PARKING LOT SEALED AND STRIPED	1994		4,138	414	15	276	(138)	2,070
26	HEAT EXCHANGE OF ROOF TOP UNITS INSTALLED	1995		2,638	264	10	264		1,716
27	WALL A/C UNITS INSTALLED	1996		1,976		15	132	132	726
28	REPAIRS TO GAS LINE	1997		3,786	189	20	189		851
29	REPLACED CARPETING	1997		795	159	5	159		716
30	INSTALLED 2 PT AC AIR & HEAT UNITS	1997		2,376		15	158	158	712
31	WATER HEATER & INSTALLATION	1998		780		10	78	78	273
32	ENTRANCE SIGN	1999		1,002	200	5	200		500
33	GAZEBO WITH RAMP AND RAILINGS	1999		3,377	169	20	169		422
34	LANDSCAPING	1999		978	196	5	196		490
35	repairs to damaged asphalt, seal/stripe parking lot	1999		2,101	210	10	210		525
36	INSTALL TILE FLOORING	2000		22,927	2,293	10	2,293		3,439

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	INSTALL SHOWER FAUCET REPLACEMENTS	2000	\$ 1,731	\$ 173	10	\$ 173	\$	\$ 260	37
38	INSTALL CARPET ON WALLS	2000	4,898	980	10	980		1,470	38
39	WATER GARDEN	2000	922	92	5	92		138	39
40	remove & replace damaged asphalt & fill cracks in parking lot	2001	10,546	351	15	352	1	352	40
41	replace bathroom floor tiles on A&B hall	2001	2,994	150	10	150		150	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 822,953	\$ 6,565		\$ 20,545	\$ 13,980	\$ 547,050	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 117,129	\$ 1,342	\$ 11,692	\$ 10,350	VAR	\$ 65,978	71
72	Current Year Purchases	15,178	15,178	1,823	(13,355)	VAR	1,823	72
73	Fully Depreciated Assets	93,223				VAR	93,218	73
74								74
75	TOTALS	\$ 225,530	\$ 16,520	\$ 13,515	\$ (3,005)		\$ 161,019	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	JAMESTOWN ALLOCATION			\$	\$ 1,288	\$ 1,288	\$		\$ 10,939	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 1,288	\$ 1,288	\$		\$ 10,939	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,067,275	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,373	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,348	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,975	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 719,008	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: **NOT APPLICABLE**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **114**

Description: **STORAGE**

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.  <u>we only hire trained aides</u>	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2	3	4
		Facility				
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3 & 39/2	hrs	\$	391	\$ 20,549	\$ 680	391	\$ 21,229	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		168	11,690		168	11,690	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		542	28,517		542	28,517	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				23,979		23,979	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12	medical supplies, tube feeding, oxygen									12
13	Other (specify): and iv supplies	39/2					7,197		7,197	13
14	TOTAL			\$	1,101	\$ 60,756	\$ 31,856	1,101	\$ 92,612	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 94,526	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	421,620		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	22,932		5
6	Prepaid Insurance	7,909		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>income tax deposit</u>	2,400		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 549,387	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	97,151		15
16	Equipment, at Historical Cost	193,019		16
17	Accumulated Depreciation (book methods)	(233,808)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>loan to Twin Willows</u> )	18,057		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 74,419	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 623,806	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 38,591	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,591		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,544		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>401K LIABILITY</u>	13,037		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 95,763	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 95,763	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 528,043	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 623,806	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>506,844</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2000 state &amp; federal taxes</b>	<b>(2,073)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>504,771</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>23,272</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>23,272</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>528,043</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,932,497	1
2	Discounts and Allowances for all Levels	25,749	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,958,246	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	149,070	6
7	Oxygen	6,260	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 155,330	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	6,709	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 6,709	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,120,285	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	423,590	31
32	Health Care	864,046	32
33	General Administration	431,051	33
	<b>B. Capital Expense</b>		
34	Ownership	245,199	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	92,612	35
36	Provider Participation Fee	40,515	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,097,013	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	23,272	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 23,272	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. state taxes are ded. On fed return

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



## STATE OF ILLINOIS

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Facility Name &amp; ID Number FAIR ACRES NURSING HOME

# 0027367

Report Period Beginning: 01/01/01

Ending:

12/31/01

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,840	2,080	\$ 38,784	\$ 18.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,078	4,362	65,580	15.03	3
4	Licensed Practical Nurses	12,081	13,082	175,850	13.44	4
5	Nurse Aides & Orderlies	35,263	37,664	357,162	9.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,361	1,593	14,383	9.03	8
9	Activity Director	2,759	2,994	28,500	9.52	9
10	Activity Assistants					10
11	Social Service Workers	1,755	1,920	21,936	11.43	11
12	Dietician					12
13	Food Service Supervisor	1,930	2,105	20,318	9.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,585	10,508	86,083	8.19	15
16	Dishwashers					16
17	Maintenance Workers	1,868	1,989	24,559	12.35	17
18	Housekeepers	5,625	6,015	58,354	9.70	18
19	Laundry	4,101	4,451	41,292	9.28	19
20	Administrator	1,912	2,080	46,737	22.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,781	1,984	22,650	11.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>WARD CLERK</u>	1,456	1,506	14,222	9.44	33
34	TOTAL (lines 1 - 33)	87,395	94,333	\$ 1,016,410 *	\$ 10.77	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	120	\$ 6,131	L1/C3	35
36	Medical Director		900	L9/C3	36
37	Medical Records Consultant		400	L10/C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		420	L10/C3	39
40	Physical Therapy Consultant	136	8,148	L10A/C3	40
41	Occupational Therapy Consultant	1	75	L10A/C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	24	1,586	L10A/C3	43
44	Activity Consultant	42	2,160	L11/C3	44
45	Social Service Consultant	42	2,160	L12/C3	45
46	Other(specify) <u>UR REVIEW</u>		900	L10/C3	46
47	<u>PURCHASING CONSULTANT</u>		1,025	L19/C3	47
48	<u>BILLING CONSULTANT</u>		1,604	L19/C3	48
49	TOTAL (lines 35 - 48)	365	\$ 25,509		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	6,525	105,655	L10/C3	52
53	TOTAL (lines 50 - 52)	6,525	\$ 105,655		53

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number FAIR ACRES NURSING HOME

STATE OF ILLINOIS

# 0027367

Report Period Beginning:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 9 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 40515 LIC BED TAX  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,821 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

FAIR ACRES NURSING HOME INC #0027367  
 RECLASSIFICATIONS ON DPA COST REPORT  
 PAGES 3 & 4 COLUMN 5  
 12/31/2001

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
22	EMPLOYEE BENEFITS	1821	
2	FOOD PURCHASES		1821
	RECLASSIFY EMPLOYEE MEALS		
2	FOOD PURCHASES	4672	
10	NURSING & MEDICAL RECORDS		4672
	RECLASSIFY FOOD SUPPLEMENTS		
VARIOUS	VARIOUS LINE ITEMS	85658	
19	PROFESSIONAL SERVICES		85658
	SEE SCHVIII FOR BREAKDOWN		